

**WAIVER OF MEDICAL REVIEW**

(Section 28-33-34.1 of the R.I. Workers' Compensation Act)

State of Rhode Island  
Workers' Compensation Court  
Medical Advisory Board  
One Dorrance Plaza  
Providence, RI 02903-3973  
Phone: 401-458-3460  
TDD: 401-458-5275

**EMPLOYEE INFORMATION:**

Social Security No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**EMPLOYER INFORMATION:**

FEIN: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**INJURY INFORMATION:** Date of Injury: \_\_\_\_\_

**Medical Review Waived      26 week      39 week      52 week      other \_\_\_\_\_**

The undersigned requests that the medical review of the employee be waived for the following reason:

- \_\_\_\_\_ the employee is receiving benefits for total incapacity, and the employee's condition is so severe or permanent that examination and review is clearly inappropriate and unnecessary;
- \_\_\_\_\_ the employee's return to work or a suspension of benefits for other reasons is imminent;
- \_\_\_\_\_ the employee is under and following a rehabilitation program approved by the Director of Labor;
- \_\_\_\_\_ the employee's condition has been previously reviewed by the attending physician, comprehensive independent health care review team or impartial medical examiner, or in an approved rehabilitation program and was then determined to be and remains stable and at maximum medical improvement, and the employee has had an earnings capacity adjustment appropriate to his or her present level of earnings capacity; or
- \_\_\_\_\_ the employee is receiving weekly compensation benefits from a self-insured employer that has filed and received approval of a request for exemption from the provisions of section 28-33-34.1 of the Rhode Island Workers' Compensation Act.
- \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_  
Employer/Carrier (Type or Print)

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date of Report